NEW YORK STATE PUBLIC HEALTH LAW
ARTICLE 44
-HEALTH MAINTENANCE ORGANIZATIONS-
For Illustrative Purposes Only

§4400. Statement of policy and purposes.

Encouraging the expansion of health care services options available to the citizens of the state is a matter of vital state concern. Without such an expansion, increased health insurance and other benefits will continue to escalate the costs of medical care and overload the health care delivery system. The health maintenance organization concept, through which members of an enrolled population are each entitled to receive comprehensive health services for an advance or periodic charge, represents a promising new alternative for the delivery of a full range of health care services at a reasonable cost.

Accordingly, it shall be the policy of this state to expand the health care services options available, and to assure greater choice in the selection of a health care plan, by removal of legal and other impediments to the development of competitive health maintenance organizations acceptable to the public.

It is the intent of the legislature that the commissioner therefore establish a comprehensive system of authorization and regulation of health maintenance organizations in the state, as provided in this article, in order to assure that health services of good quality be provided to all citizens who choose to take advantage of that alternative to meet their health care needs. The commissioner shall cooperate with the superintendent of insurance and with other state officials and agencies which establish standards and requirements pertaining to the provision and financing of health care services in order to assure necessary, equitable and consistent state supervision of all health care systems without duplication of inspection or services.

§4401. Definitions.

For the purpose of this article:

1. "Health maintenance organization" or "organization" means any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan.

2. "Comprehensive health services plan" or "plan" means a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge. A plan may include the provision

of health care services which are covered by the organization at the election of enrollees by health care providers not participating in the plan pursuant to a contract, employment or other association to the extent authorized in section forty-four hundred six of this article; provided, however, that in no event shall an enrollee elect to have a non-participating provider serve as the enrollee's primary care practitioner responsible for supervising and coordinating the care of the enrollee.

3. "Comprehensive health services" means all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services. Such term may be further defined by agreement with enrolled populations providing additional benefit necessary, desirable or appropriate to meet their health care needs.

4. "Enrolled population" means a group of persons, defined as to probable age, sex and family composition, which receives comprehensive health services from a health maintenance organization in consideration for a basic advance or periodic charge.

5. "Superintendent" means the superintendent of insurance of the state of New York.

*6. "Comprehensive HIV special needs plan" means a health maintenance organization certified pursuant to section forty-four hundred three-c of this article which, in addition to providing or arranging for the provision of comprehensive health services on a capitated basis, including those for which medical assistance payment is authorized pursuant to section three hundred sixty-five-a of the social services law, also provides or arranges for the provision of HIV care to HIV positive persons eligible to receive benefits under title XIX of the federal social security act or other public programs.
*NB Repealed March 31, 2006

*7. "HIV Center of excellence" is defined as a health care facility certified to operate under article twenty-eight of this chapter that offers specialized treatment expertise in HIV care services as defined by the commissioner.
*NB Repealed March 31, 2006

§4402. Health maintenance organizations; application for certificate of authority.

1. No person or groups of persons may operate a health maintenance organization or issue a contract to an enrollee for membership in a comprehensive health services plan without first obtaining a certificate of authority from the commissioner.

2. In order to receive such a certificate of authority, a person or persons, hereinafter designated as the applicant, intending to operate a health maintenance organization shall file an application for such certificate on such form as the commissioner shall prescribe, and shall provide to the satisfaction of the commissioner the following:

(a) a copy of each of the basic organizational documents and agreements of the applicant and all participating entities, including all contracts and agreements relating to the provision of comprehensive health services;

(b) a copy of the bylaws, rules and regulations on internal governing documents of the applicant;

(c) a list of the names, addresses and official positions of the persons comprising the applicant and all entities referred to in paragraph (a) other than those possessing a valid operating certificate under the provisions of article twenty-eight of this chapter, including all owners of record or beneficial, all members of the governing body, the officers and directors in the case of a corporation, and the partners or members in the case of a partnership or corporation, and the agent for service of process;

(d) a statement of the financial condition of the organization, including, if appropriate, an income statement, balance sheet and projected sources and uses of funds;

(e) a statement generally describing the proposed operation of the health maintenance organization as to the location of its facilities, the type and quantity of health care personnel engaged to provide services, its quality assurance mechanism, its grievance procedure, participating hospitals and such other data as may be required by the commissioner;

(f) a copy of each enrollee contract filed with and approved by the superintendent pursuant to section forty-four hundred six of this article; and

(g) such other information as may be required by the commissioner to make the determinations required in section forty-four hundred three of this article.

§4403. Health maintenance organizations; issuance of certificate of authority.

1. The commissioner shall not issue a certificate of authority to an applicant therefor unless the applicant demonstrates that:

(a) it has defined a proposed enrolled population to which the health maintenance organization proposes to provide comprehensive health services and has established a mechanism by which that population may advise in determining the policies of the

organization;

(b) it has the capability of organizing, marketing, managing, promoting and operating a comprehensive health services plan;

(c) it is financially responsible and may be expected to meet its obligations to its enrolled members. For the purpose of this paragraph, "financially responsible" means that the applicant shall assume full financial risk on a prospective basis for the provision of comprehensive health services, including hospital care and emergency medical services within the area served by the plan, except that it may require providers to share financial risk under the terms of their contract, it may have financial incentive arrangements with providers or it may obtain insurance or make other arrangements for the cost of providing comprehensive health services to enrollees; any insurance or other arrangement required by this paragraph shall be approved as to adequacy by the superintendent as a prerequisite to the issuance of any certificate of authority by the commissioner;

(d) the character, competence, and standing in the community of the proposed incorporators, directors, sponsors or stockholders, are satisfactory to the commissioner;

(e) the prepayment mechanism of its comprehensive health services plan, the bases upon which providers of health care are compensated, and the anticipated use of allied health personnel are conducive to the use of ambulatory care and the efficient use of hospital services;

(f) acceptable procedures have been established to monitor the quality of care provided by the plan, which, in the case of services provided by non-participating providers, shall be limited to the provision of reports to the primary care practitioner responsible for supervising and coordinating the care of the enrollee;

(g) approved mechanisms exist to resolve complaints and grievances initiated by any enrolled member; and

(h) the contract between the enrollee and the organization meet the requirements of the superintendent as set forth in section forty-four hundred six of this article, as to the provisions contained therein for health services, the procedures for offering, renewing, converting and terminating contracts to enrollees, and the rates for such contracts including but not limited to, compliance with the provisions of section one thousand one hundred nine of the insurance law.

2. The commissioner may adopt and amend rules and regulations pursuant to the state administrative procedure act to effectuate the purposes and provisions of this article. Such regulations may include rules and procedures addressing the provision of emergency services, including patient notification, obtaining authorization for treatment, transfer of

patients from one facility to another and emergency transportation arrangements.

3. Nothing contained in this section shall preclude any person or persons in developing a health maintenance organization from contacting potential participants to discuss the health care services such organization would offer, prior to the granting of a certificate of authority.

4. Nothing in this article shall preclude any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or which would authorize enrollees to receive assistance from federal funds.

5.(a) The commissioner, at the time of initial licensure, at least every three years thereafter, and upon application for expansion of service area, shall ensure that the health maintenance organization maintains a network of health care providers adequate to meet the comprehensive health needs of its enrollees and to provide an appropriate choice of providers sufficient to provide the services covered under its enrollee's contracts by determining that

(i) there are a sufficient number of geographically accessible participating providers;

(ii) there are opportunities to select from at least three primary care providers pursuant to travel and distance time standards, providing that such standards account for the conditions of accessing providers in rural areas;

(iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrollment population;

(iv) there is no exclusion of any appropriately licensed type of provider as a class; and

(v) contracts entered into with health care providers neither transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of this section, nor penalize providers for unfavorable case mix so as to jeopardize the quality of or enrollees' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

(b) The following criteria shall be considered by the commissioner at the time of a review:

(i) the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disability Act to assure access to health care for the enrollee population;

(ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; and

(iii) with the exception of initial licensure, the number of grievances filed by enrollees relating to waiting times for appointments, appropriateness of referrals and other indicators of plan capacity.

(c) Each organization shall report on an annual basis the number of enrollees and the number of participating providers in each organization.

6. (a) If a health maintenance organization determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the health maintenance organization shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(b) A health maintenance organization shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. If the health maintenance organization, or the primary care provider in consultation with the medical director of the organization and specialist if any, determines that such a standing referral is appropriate, the organization shall make such a referral to a specialist. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialist, except pursuant to the provisions of paragraph (a) of this subdivision. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the specialist, and the enrollee or the enrollee's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(c) A health maintenance organization shall have a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, with

(i) a life-threatening condition or disease or

(ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If the health maintenance organization, or primary care provider in consultation with a medical director of the organization and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the organization shall refer the enrollee to such specialist. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialist, except pursuant to the provisions of paragraph (a) of this subdivision. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization, in consultation with the primary care provider if appropriate, the specialist, and the enrollee or the enrollee's designee. Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If an organization refers an enrollee to a non-participating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(d) A health maintenance organization shall have a procedure by which an enrollee with

(i) a life-threatening condition or disease or

(ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the health maintenance organization, or the primary care provider or the specialist designated pursuant to paragraph (c) of this subdivision, in consultation with a medical director of the organization, determines that the enrollee's care would most appropriately be provided by such a specialty care center, the organization shall refer the enrollee to such center. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialty care center, unless the organization does not have an appropriate specialty care center to treat the enrollee's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the health maintenance organization, in consultation with the primary

care provider, if any, or a specialist designated pursuant to paragraph c of this subdivision, and the enrollee or the enrollee's designee. If an organization refers an enrollee to a specialty care center that does not participate in the organization's network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network. For purposes of this paragraph, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(e) (1) If an enrollee's health care provider leaves the health maintenance organization's network of providers for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph a of subdivision two of section forty-four hundred six-d of this chapter, the health maintenance organization shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of

(i) up to ninety days from the date of notice to the enrollee of the provider's disaffiliation from the organization's network; or

(ii) if the enrollee has entered the second trimester of pregnancy at the time of the provider's disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions of subparagraph one of this paragraph, such care shall be authorized by the health maintenance organization during the transitional period only if the health care provider agrees

(i) to continue to accept reimbursement from the health maintenance organization at the rates applicable prior to the start of the transitional period as payment in full;

(ii) to adhere to the organization's quality assurance requirements and to provide to the organization necessary medical information related to such care; and

(iii) to otherwise adhere to the organization's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization.

(f) If a new enrollee whose health care provider is not a member of the health maintenance organization's provider network enrolls in the health maintenance

organization, the organization shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of up to sixty days from the effective date of enrollment, if

(i) the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition or

(ii) the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the health maintenance organization for the transitional period only if the health care provider agrees (A) to accept reimbursement from the health maintenance organization at rates established by the health maintenance organization as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the health maintenance organization's network for such services; (B) to adhere to the organization's quality assurance requirements and agrees to provide to the organization necessary medical information related to such care; and (C) to otherwise adhere to the organization's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization. In no event shall this paragraph be construed to require a health maintenance organization to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the subscriber's contract.

* **§4403-a. Special purpose certificate of authority.**

1. The commissioner may issue a special purpose certificate of authority to a provider, applying on forms prescribed by the commissioner, seeking to offer a comprehensive health services plan on a prepaid contractual basis either directly, or through an arrangement, agreement or plan or combination thereof to an enrolled population, which is substantially composed of persons eligible to receive benefits under title XIX of the federal social security act or other public programs.

2. A not-for-profit corporation established to operate a hospital pursuant to article twenty-eight of this chapter, a government agency, an entity or a group of entities seeking to provide comprehensive health services pursuant to the provisions of this section may apply for a special purpose certificate of authority; provided, however, that a shared health facility, as defined by article forty-seven of the public health law, shall not be eligible for such a certificate.

3. The commissioner shall not issue a special purpose certificate of authority

unless the applicant has demonstrated to the commissioner's satisfaction that the requirements of this article and any regulations promulgated pursuant thereto have been met and will continue to be met, provided, however, that the commissioner may waive one or more of such requirements, or portions thereof, pertaining to financial risk, employer requirements and subscriber contracts if he determines that such waiver will serve to promote the efficient provision of comprehensive health services and that the proposed plan will provide an appropriate and cost-effective alternative method for the delivery of such services in a manner which will meet the needs of the population to be served.

4. (a) No contract for the provision of comprehensive health services pursuant to this section shall be entered into by a local social services district unless the commissioner certifies that all pertinent requirements with respect to financial arrangements, rates, and standards relating to arrangements for and the delivery of patient care services have been satisfied and that the contract and related arrangements will ensure access to and the delivery of high quality, appropriate medical services including an assurance that recipients' access to preventive health services is not diminished.

(b) No contract for the provision of comprehensive health services to persons eligible for medical assistance under title eleven of article five of the social services law shall be entered into without the approval of the commissioner of social services pursuant to section three hundred sixty-five-a of the social services law and the state director of the budget. The commissioner of social services shall not approve such a contract unless the contract:

(i) provides that enrollment shall be voluntary and contains provisions to ensure that persons eligible for medical assistance will be provided sufficient information regarding the plan to make an informed and voluntary choice whether to enroll or, in the event that enrollment in the entity is pursuant to section three hundred sixty-four-j of the social services law, provides that enrollment in the entity is governed by that section;

(ii) provides adequate safeguards to protect persons eligible for medical assistance from being misled concerning the plan and from being coerced into enrolling in the plan or, in the event that enrollment in the entity is undertaken pursuant to section three hundred sixty-four-j of the social services law, provides that enrollment in the entity is governed by that section;

(iii) establishes adequate opportunities for public review and comment prior to implementation of the plan;

(iv) provides adequate grievance procedures for recipients who

enroll in the plan; and

(v) establishes quality assurance mechanisms.

5. A special purpose certificate of authority shall be issued to an approved provider of comprehensive health services for a maximum effective period of twenty-four months subject to the applicable provisions of section forty-four hundred four of this article and provided that federal financial participation is available for expenditures made on behalf of recipients of medical assistance. The commissioner upon application, after consultation with the commissioner of social services, may issue a certificate for an additional period of up to twenty-four months if satisfied that the plan has and will continue to demonstrate satisfactory performance and compliance with all requirements imposed for initial certification. If the plan provides comprehensive services pursuant to a contract solely to individuals eligible for medical assistance under title eleven of article five of the social services law, the certificate shall expire when (a) the medical assistance contract is revoked or expires and is not extended or renewed or (b) federal approval of the medical assistance contract is withdrawn.

6. All individuals eligible for medical assistance enrolling voluntarily in a comprehensive health services plan offered by an entity with a special purpose certificate of authority will be given thirty days from the effective date of enrollment in the plan to disenroll without cause. After this thirty-day disenrollment period, all individuals participating in the plan will be enrolled for a period of six months, except that all participants will be permitted to disenroll for good cause, as defined by the commissioner of social services in regulation.

7. Notwithstanding any inconsistent provision of this section, the commissioner shall issue special purpose certificates of authority pursuant to this section to no more than eighteen entities other than those entities initially authorized by chapter seven hundred fifteen of the laws of nineteen hundred eighty-two and by a chapter of the laws of nineteen hundred eighty-four authorizing the Monroe county medicap demonstration project.
*NB Expires March 31, 2006

***§4403-b. Development of comprehensive health services plans.**

The commissioner is authorized, after consultation with the commissioner of social services, and subject to the approval of the director of the budget, to make grants to diagnostic and treatment centers and general hospitals operating pursuant to article twenty-eight of this chapter, to aid in the planning, development and implementation of comprehensive health services plans. The total amount expended pursuant to this section shall not exceed the amount appropriated for such purposes in any fiscal year.
*NB Expires March 31, 2006

***§4403-c. Comprehensive HIV special needs plan certification.**

1. No person or group of persons may operate a comprehensive HIV special needs plan without first obtaining a certificate of authority from the commissioner. Any person may apply for a comprehensive HIV special needs certificate of authority, provided, however, that a shared health facility, as defined in article forty-seven of this chapter, shall not be eligible for such a certificate.

2. An applicant for certification shall submit the following information and documentation to the satisfaction of the commissioner:

(a) a copy of the applicant's basic organizational documents and agreements of the applicant and all network members, including all and agreements relating to the provision of HIV services;

(b) a copy of any current licensure or certification maintained by the applicant;

(c) a description of any experience the applicant may have had in providing HIV services which are licensed, certified, funded or approved by the department, including identification of any disciplinary, administrative or criminal proceedings related to such services in the past ten years, the resolution thereof, and any other proceedings currently pending;

(d) full disclosure of the financial condition of the applicant and of members of the board, officers, controlling persons, owners and partners, including, but not limited to, a statement of the applicant's assets, resources, accounts receivable, liabilities and proposed sources and uses of funds and the most recent certified income statement and balance sheet;

(e) a demonstration of the applicant's ability to provide or continue to provide quality HIV services;

(f) a description of the geographic area served and to be served by the applicant;

(g) a description of the applicant's current capacity, and proposed capacity, to provide or arrange for the provision of comprehensive HIV services for a defined geographic area to a defined population; and

(h) such other information as the commissioner shall require.

3. The commissioner shall not issue a comprehensive HIV special needs plan

certificate of authority to an applicant therefor unless the applicant demonstrates that:

(a) it has defined an enrolled population to which the comprehensive HIV special needs plan proposes to provide comprehensive HIV health services, has demonstrated a willingness to enroll any person who is eligible for enrollment within its defined catchment area and has established a mechanism by which the enrolled population may participate in determining the policies of the organization;

(b) it has defined a specific network of providers and facilities that are capable of providing comprehensive HIV special needs services to the enrolled population described in paragraph (a) of this subdivision;

(c) it has the capability of organizing, marketing, managing, promoting and operating a comprehensive HIV special needs plan;

(d) it is financially responsible and sound and may be expected to meet its obligations to its enrolled members. For the purposes of this paragraph, "financially responsible" means that the applicant is capable of assuming full financial risk on a prospective basis for the provision of comprehensive HIV special needs services within the geographic catchment area defined by the applicant except that it may allow providers to share financial risk under the terms of their contract, or it may obtain insurance or make other arrangements for the cost of providing comprehensive HIV special needs health services to enrollees; any insurance or other arrangements proposed to meet this requirement shall be approved as to adequacy as a prerequisite to the issuance of any comprehensive HIV special needs certificate of authority by the commissioner. In making a determination of financial soundness, the commissioner shall consider financial information, contracts and agreements required as part of the application for a certificate of authority and any other information that the commissioner shall deem necessary to make that determination. For purposes of this section, any grants awarded to an applicant contingent upon its approval as a HIV special needs plan certified pursuant to this section, shall be considered when making a determination of fiscal soundness;

(e) it has established a system which appropriately accounts for costs and a uniform system of reports and audits meeting the requirements of the commissioner;

(f) the character, competence and standing in the community of the proposed incorporators, directors, sponsors, or stockholders of the plan, and its network providers, are satisfactory to the commissioner;

(g) it is willing and able to assure that necessary HIV services will be provided in a timely manner to assure the availability and accessibility of adequate personnel and facilities; to assure continuity of care for enrollees; and to implement procedures for

referrals, as requested, to appropriate care for affected family members of the enrolled population;

(h) the prepayment mechanism of its comprehensive HIV special needs plan, the bases upon which the providers of health care are compensated, and the anticipated use of allied health personnel are conducive to the use of ambulatory care and the efficient use of hospital services;

(i) acceptable procedures have been established for the conduct of outreach and enrollment of persons with HIV infection including persons who are homeless, substance users and other vulnerable populations;

(j) acceptable procedures have been developed to communicate with participants in a linguistically and culturally competent manner;

(k) acceptable procedures have been established to monitor the quality of care provided by the plan and to assure that all care rendered meets clinical standards of HIV care as established and maintained by the AIDS Institute of the New York state department of health;

(l) approved mechanisms exist to resolve complaints and grievances initiated by any enrolled member; and

(m) the requirements of this article and any regulations promulgated pursuant thereto have been met and will continue to be met.

4. The commissioner shall not issue a comprehensive HIV special needs certificate of authority unless the applicant has demonstrated to the commissioner's satisfaction that the requirements of this article and any regulations promulgated pursuant thereto have been met and will continue to be met, provided, however, that the commissioner may impose alternative requirements, or portions thereof, particularly those related to capitalization, if he or she determines that such alternative requirements will serve to promote the high quality, efficient provision of comprehensive health services or services required by HIV positive persons, will promote the development of HIV special needs plans and that the proposed plan will provide an appropriate and cost-effective alternative method for the delivery of such services in a manner which will meet the needs of the population to be served.

5. The commissioner shall make a determination on an application after receipt of all required and requested information and documentation.

6. The commissioner shall review and approve any current or proposed contracts or agreements with current or prospective network members, and provided further, that the

commissioner shall specifically review and approve any proposed provisions in such contracts or agreements with the prospective or existing network members which specify any risk sharing arrangements.

7. The commissioner may revoke, limit or annul a comprehensive HIV special needs plan certificate of authority in accordance with the provisions of section forty-four hundred four of this article.

8. A comprehensive HIV special needs plan, certified pursuant to this section, shall be responsible for providing or arranging for all medical assistance services defined under section three hundred sixty-five-a of the social services law, including delivery of a comprehensive benefit package, which shall include early and periodic screening; adolescent health; diagnosis and treatment and child/teen health screenings; referrals for necessary services; linkages to HIV counseling and testing; and HIV prevention and education activities. A comprehensive HIV special needs plan provider shall be responsible for assisting enrollees in the prudent selection of such services including but not limited to:

(a) referral, coordination, monitoring and follow-up with regard to other medical services providers, as appropriate for diagnosis and treatment, or direct provision of all medical assistance services;

(b) methods of assuring enrollees' access to specialty services outside the comprehensive HIV special needs plan's network or panel when the plan does not have a provider with the appropriate training and experience in its network to meet the particular health care needs of the participant;

(c) the establishment of appropriate utilization and referral requirements for physicians, hospitals, and other medical services providers, including emergency room visits and inpatient admissions;

(d) the creation of mechanisms to ensure the participation of HIV centers of excellence and community-based HIV care providers;

(e) implementation of procedures for managing the care of all participants, including the use of facility and community-based case managers with expertise in the care needs of persons with HIV infection, and the designation of a specialist as a primary care practitioner;

(f) development of appropriate methods of managing the HIV care needs of homeless, substance users and other vulnerable populations, who are enrolled in the comprehensive HIV special needs plan, to assure that all necessary services are made available in a timely manner, in accordance with prevailing standards of professional

medical practice, and that all appropriate referrals and follow-up treatments are provided;

(g) provision of all early periodic screening, diagnosis and treatment services, as well as periodic screening and referral, to each participant under the age of twenty-one, at regular intervals and as medically appropriate;

(h) direct provision of or arrangement for the provision of comprehensive prenatal care services to all pregnant participants including all services enumerated in subdivision one of section twenty-five hundred twenty-two of this chapter in accordance with standards adopted by the department of health pursuant to such section and with statute and regulations governing HIV testing of pregnant women and newborns;

(i) implementation of procedures for written agreements, which may include contractual agreements, with community-based social service providers to ensure access to the full continuum of services needed by HIV infected persons; and

(j) permit the use of standing referrals to specialists and subspecialists for participants who require the care of such practitioners on a regular basis.

9. Notwithstanding any other provision of law, a comprehensive HIV special needs plan certified pursuant to this section shall limit enrollment to HIV positive persons but may enroll related children up to the age of nineteen regardless of their HIV status.

10. Enrollment and disenrollment. (a) Enrollment in a comprehensive HIV special needs plan shall be voluntary and persons eligible for enrollment in such plans shall be afforded the opportunity to choose among such plans, to the extent available in the locality where the person currently resides; provided however that enrollment may be automatic after federal approval of a waiver or waivers or other federal action required to institute automatic enrollment, pursuant to applicable provisions of the federal social security act, and that persons automatically enrolled in a comprehensive HIV special needs plan shall have the opportunity to withdraw from such plan in accordance with paragraph (g) of subdivision four, paragragh (b) of subdivision three and subdivision twelve of section three hundred sixty-four-j of the social services law. The department shall ensure to the maximum extent practicable that individuals are provided with a choice of comprehensive HIV special needs plans.

(b) The commissioner shall promulgate regulations establishing criteria, which relate to enrollment and disenrollment of enrollees in comprehensive HIV special needs plans. Comprehensive HIV special needs plans shall not request disenrollment of an enrollee based on any diagnosis, condition, or perceived diagnosis or condition, or an enrollee's efforts to exercise his or her rights under a grievance process.

(c) Prior to enrollment in a comprehensive HIV special needs plan individuals are

to be provided with a full written explanation of all fee-for-service and other options and given a reasonable opportunity to choose between the comprehensive HIV special needs plan and the other options. In addition, enrollees shall be provided notice of their right to disenroll from the plan, except as otherwise provided in this subdivision.

(d) If an enrollee requests to change a provider or disenroll from a comprehensive HIV special needs plan pursuant to this subdivision, the social services district and the plan shall implement such change in a timely manner in accordance with standards established by the commissioner. When an enrollee changes comprehensive HIV special needs plan providers the plan must effectuate the timely transfer of all necessary medical records.

(e) Plans shall ensure that any new enrollee whose health care provider is not a member of the plan's provider network, who enrolls in the plan, can continue with an ongoing course of treatment with the enrollee's current health care provider during a transitional period of up to sixty days from the effective date of enrollment. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the comprehensive HIV special needs plan for the transitional period only if the health care provider agrees: (1) to accept reimbursement from the comprehensive HIV special needs plan at rates established by the plan as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the plan's network for such services; (2) to adhere to the plan's quality assurance requirements and agrees to provide to the plan any necessary medical information related to such care; and (3) to otherwise adhere to the plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the comprehensive HIV special needs plan. In no event shall this paragraph be construed to require a comprehensive HIV special needs plan to provide coverage for benefits not otherwise covered;

(f) Comprehensive HIV special needs plans shall ensure that for those enrollees whose health care provider leaves the comprehensive HIV special needs plan's network of providers, the enrollee shall be permitted to continue an ongoing course of treatment with such current health care provider during a transitional period of up to ninety days from the date of notice to the enrollee of the provider's disaffiliation from the plan's network. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the comprehensive HIV special needs plan for the transitional period only if the health care provider agrees:

(1) to accept reimbursement from the comprehensive HIV special needs plan at rates established by the plan as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the plan's network for such services;

(2) to adhere to the organization's quality assurance requirements and agrees to provide to the plan any necessary medical information related to such care; and

(3) to otherwise adhere to the plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the comprehensive HIV special needs plan. In no event shall this paragraph be construed to require a comprehensive HIV special needs plan to provide coverage for benefits not otherwise covered;

11. The commissioner shall develop and certify capitated payment rates for comprehensive HIV special needs plans, subject to the approval of the director of the division of the budget. In developing capitation rates the commissioner shall be authorized to consider, at a minimum, the age, eligibility category, historic cost and utilization of covered enrollees and covered services, anticipated costs of emerging HIV treatment modalities and the expected impact of delivering services in a managed care environment.

12. Plans certified under this section must submit financial reports in a manner and frequency established by the commissioner.

13. The department shall establish a stop-loss reinsurance program for comprehensive HIV special needs plans. The stop-loss reinsurance program shall be designed in a manner, which promotes the development, and ongoing financial viability of the comprehensive HIV special needs plan by providing reasonable protection for catastrophic cases and adverse selection.

14. Quality assurance. (a) The department shall be responsible for establishing a comprehensive quality assurance program for comprehensive HIV special needs plans. This quality assurance program shall reflect clinical standards of HIV care established and maintained by the AIDS Institute in the department. The department shall monitor the performance, quality and utilization of such plans on at least an annual basis. Such plans must describe and document the existence of a formal, organized quality assurance program with the capacity to identify, address and follow-up on issues, which concern the care and services, delivered to enrollees. Such reviews are to include, but not be limited to, the following:

(1) compliance with performance and outcome-based quality standards promulgated by the department;

(2) appropriateness, accessibility, timeliness, and quality of care delivered by such providers;

(3) referrals, coordination, monitoring and follow-up with regard to other medical service providers;

(4) methods of ensuring enrollees access to specialty services outside the plan's network or panel when the plan does not have a provider with the appropriate training and experience in the network or panel to meet the particular HIV care needs of the participant;

(5) delivery of a comprehensive benefit package, including early and periodic screening; adolescent health; diagnosis and treatment and child/teen health screenings; referrals for necessary services, and linkages to HIV counseling and testing; HIV prevention and education activities;

(6) mechanisms for the provision of all information to enrollees in clear and coherent terms that are commonly used in a culturally and linguistically appropriate and understandable manner;

(7) existence of a management information system to support quality assurance activities, which system shall provide for the collection and utilization of data including but not limited to enrollment, complaints, encounters and specific performance indicators; and

(b) the commissioner shall have access to patient specific medical information and enrollee medical records, including encounter data, maintained by a comprehensive HIV special needs plan for the purposes of quality assurance and oversight.

(c) The department shall be responsible for establishing and maintaining a uniform system of reports relating to the quality of care and services furnished by comprehensive HIV special needs plans.

15. The commissioner may revoke, limit or annul a comprehensive HIV special needs certificate of authority in accordance with the provisions of section forty-four hundred four of this article.

16. Confidentiality. Except as provided in paragraph (c) of subdivision fourteen of this section, any enrollee information maintained by a comprehensive HIV special needs plan shall be kept confidential in accordance with section forty-four hundred eight-a of this article and where applicable section 33.13 of the mental hygiene law and any other applicable state or federal law.

17. Utilization review. A comprehensive HIV special needs plan authorized under

this section is required to meet requirements set forth in article forty-nine of this chapter.

18. Disclosure. Each enrollee and prospective enrollee prior to enrollment in a comprehensive HIV special needs plan shall be provided with written disclosure information related to enrollee benefits, rights and obligations pursuant to section forty-four hundred eight of this article.

19. Grievance procedure. Comprehensive HIV special needs plans authorized under this section shall be required to meet grievance procedures requirements pursuant to section forty-four hundred eight-a of this article.

20. Prohibitions. A comprehensive HIV special needs plan authorized under this section shall be required to meet the requirements set forth in section forty-four hundred six-c of this article.

21. The commissioner is authorized, subject to the approval of the director of the division of the budget, and within amounts appropriated, to make grants to those entities seeking certification to operate a comprehensive HIV special needs plan to aid in the development of the systems, organizational structures and networks necessary to operate a managed care program. The commissioner is authorized to develop criteria for distribution of the grants. The grants may also be used to meet the capitalization standards and the reserve and escrow deposit requirements established for comprehensive HIV special needs plans.

22. Comprehensive HIV special needs plans shall function distinctly from other comprehensive or non-comprehensive health plans operated by the same organization, corporation, persons, county or municipality and shall be clearly distinguished from any other functions through the maintenance of separate records, reports and accounts for the comprehensive HIV special needs plan function.

23. The commissioner shall establish reserve and escrow deposit requirements for HIV special needs plans.

24. Nothing in this section shall be construed to require that a health maintenance organization, certified pursuant to the provisions of this article, apply for a comprehensive HIV special needs plan certificate of authority pursuant to this section; provided, however, that a health maintenance organization, certified pursuant to the provisions of this article, which proposes to operate a comprehensive HIV special needs plan shall be required to comply with all the provisions of this section.
* NB Repealed December 31, 2003

***§ 4403-e. Primary care partial capitation providers; partial capitation certificate of authority.**

1. The commissioner may issue partial capitation certificates of authority to qualified individual medical services providers, counties or entities comprised of medical services providers, applying on forms prescribed by the commissioner, seeking to offer medical assistance services, including primary and preventive care and case management of inpatient, emergency room, specialty, and pharmacy services, to recipients of medical assistance eligible to enroll in managed care plans, on a partial capitation basis. Partial capitation certificates of authority shall only be awarded to qualified applicants in rural areas of the state where comprehensive health services plans, as defined in section forty-four hundred one of this article, are not yet available, provided that such certificate shall be awarded only until full capitation becomes practicable. Comprehensive primary and preventive care shall include all services and related ancillary procedures routinely performed in a primary care physicians office, including preventive care and immunizations in accordance with CTH periodic schedules and routine obstetrical-gynecological services. Notwithstanding, where partial capitation providers currently exist, they will be allowed to continue operation. Provided, however, that a shared health facility, as defined in article forty-seven of this chapter, shall not be eligible for such a certificate.

2. Applications for a partial capitation certificate of authority shall include the following:

(a) current licensure or certification;

(b) a description of the applicant's experience in providing the services included as part of comprehensive primary and preventive care, including identification of any disciplinary, administrative or criminal proceedings related to such license, certification or services and the resolution thereof;

(c) a description of the applicant's financial resources, together with a copy of the applicant's latest certified financial statement and the medical malpractice insurance coverage maintained by such applicant;

(d) an assessment of the applicant's ability to continue to provide high quality services in exchange for payments and to assume the financial risk of operating on a partial capitation basis;

(e) the geographic area to be served by the applicant;

(f) the applicant's current capacity, and proposed capacity to provide or directly arrange for the provision of medical care and services to persons eligible for medical assistance;

(g) a statement of intent to contract from the local social services district in which

they will operate;

(h) a statement describing procedures to be used to monitor the quality of care provided by the plan;

(i) such other information as the commissioner shall require; and

(j) in the case of an application from a local social services district, such comparable information as the commissioner may require.

3. The commissioner may issue a partial capitation certificate of authority to an applicant that meets the following criteria:

(a) the applicant can demonstrate its ability to control, arrange for and manage in-patient hospital and emergency room care through written agreements with participating hospitals;

(b) the applicant is board-certified or board-eligible in his or her area of specialty, or has completed an accredited residency program, or has admitting privileges at one or more hospitals, or in the case of an entity, all medical services providers affiliated with the applicant are board-certified or board-eligible in his or her area of specialty, has completed an accredited residency program, or has admitting privileges at one or more hospitals;

(c) the applicant directly provides or arranges for the delivery of comprehensive primary and preventive care and services and access to medical advice and emergency care on a twenty-four hour basis;

(d) the applicant has adequate medical malpractice liability insurance coverage;

(e) the applicant has demonstrated it is financially responsible and may be expected to meet its obligations to its enrolled members. For purposes of this paragraph, "financially responsible" means that the applicant shall assume financial risk on a prospective basis for the provision of comprehensive primary care and preventive services, and can support the necessary administrative costs associated with the activities of a partial capitation plan, for its enrolled members;

(f) the applicant has demonstrated the ability to provide high quality care, and to monitor the quality of care provided via an acceptable formal quality assurance program;

(g) the local social services district has provided written evidence of its intention to contract with the plan; and

(h) The applicant has demonstrated the ability to track and monitor all services provided to its enrollees, and its ability to submit periodic cost and utilization reports, as the commissioner may require.
*NB Repealed March 31, 2006

***§ 4403-f. Managed long term care plans.**

1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population which the plan is authorized to enroll.

(b) "Eligible applicant" means an entity controlled or wholly owned by one or more of the following: a hospital as defined in subdivision one of section twenty-eight hundred one of this chapter; a home care agency licensed or certified pursuant to article thirty-six of this chapter; an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of this article (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six), or a health maintenance organization authorized under article forty-three of the insurance law; or a not-for-profit organization which has a history of providing or coordinating health care services and long term care services to the elderly and disabled.

(c) "Chronically ill" shall be as defined by the commissioner.

(d) "Operating demonstration" means the following entities: the social health maintenance organization authorized by chapter six hundred two of the laws of nineteen hundred eighty-two; and the chronic care management demonstration programs authorized by chapters six hundred fifty-three of the laws of nineteen hundred eighty-four, chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(e) "Approved managed long term care demonstration" means the sites approved by the commissioner to participate in the "Evaluated Medicaid Long Term Care Capitation Program"; the chronic care management demonstration program authorized by chapter thirty-nine of the laws of nine- teen hundred ninety-seven; and any demonstration authorized pursuant to paragraphs (d) and (e) of subdivision six of this section.

(f) "Health and long term care services" means services including, but not limited to primary care, acute care, home and community-based and institution-based long term care

and ancillary services that are necessary to meet the needs of persons whom the plan is authorized to enroll.

2. Certificate of authority; form. An eligible applicant shall submit an application for a certificate of authority to operate a managed long term care plan upon forms, and within such time, as may be prescribed by the commissioner. Such eligible applicant shall submit information and documentation to the commissioner which shall include, but not be limited to:

(a) a description of the service area proposed to be served by the plan with projections of enrollment that will result in a fiscally sound plan;

(b) a description of the proposed target population and the marketing plan;

(c) a description that demonstrates the cost-effectiveness of the program as compared to the cost of services clients would otherwise have received;

(d) adequate documentation of the appropriate licenses, certifications or approvals to provide care as planned, including, if appropriate, affiliation agreements or contracts with such providers as may be necessary to provide the full complement of services required to be provided under this section.

3. Certificate of authority; approval. The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

(a) the relative cost effectiveness to the medical assistance program when compared to other managed long term care plans proposing to serve, or serving, comparable populations;

(b) that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

(c) that it will include an enrollment process which shall ensure that enrollment in the plan is informed and voluntary by enrollees or their representatives and a voluntary disenrollment process. The application shall include the specific grounds that would warrant involuntary disenrollment provided, however, an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

(d) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

(e) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

(f) readiness and capability to: achieve full capitation on a scheduled basis for services reimbursed pursuant to title XVIII of the federal social security act or capability and protocols for benefit coordination for services reimbursed pursuant to such title and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

(g) readiness and capability to achieve full capitation on a scheduled basis for services reimbursed pursuant to title XIX of the federal social security act;

(h) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law; and

(i) that the arrangements for health and long term care services ensure the availability and accessibility of such services to the proposed enrolled population.

4. Role of the superintendent of insurance.

(a) The superintendent of insurance, in consultation with the commissioner with regard to fiscal solvency, shall be responsible for evaluating, approving and regulating all matters relating to premium rates subject to paragraph (c) of this subdivision, enrollee contracts and fiscal solvency, including reserves, surplus and provider contracts to the extent such contracts relate to fiscal solvency matters. The superintendent of insurance may promulgate regulations to implement this section. The superintendent of insurance, in the administration of this subdivision:

(i) shall be guided by the standards which govern the fiscal solvency of a health maintenance organization, provided, however, that the superintendent of insurance shall recognize the specific delivery components, operational capacity and financial capability of the eligible applicant for a certificate of authority;

(ii) shall not apply financial solvency standards that exceed those required for a health maintenance organization;

(iii) shall establish reasonable capitalization and contingency reserve requirements. Where the population enrolled in a managed long term care plan is substantially composed of chronically ill individuals receiving services under title XIX of the federal social security act, the superintendent of insurance shall take into consideration the avail- ability of services to such chronically ill individuals under such title in the event that the managed long term care plan is unable to meet its contractual obligations. The establishment of reasonable capitalization and contingency reserve requirements for managed long term care plans substantially composed of chronically ill individuals receiving services under title XIX of the federal social security act shall also be subject to the approval of the commissioner;

(iv) when establishing capitalization and contingency reserve requirements, may exclude revenue and expenses derived from chronically ill individuals under title XIX of the federal social security act who are in a nursing facility in a managed long term care plan.

(b) Standards established pursuant to this subdivision shall be adequate to protect the interests of enrollees in managed long term care plans. The superintendent of insurance shall be satisfied that the eligible applicant is financially sound, and has made adequate provisions to pay for services:

(i) that are furnished by providers that are not affiliated with the eligible applicant;

(ii) to meet the specialized health care needs of enrollees needing care at specialty care centers; and

(iii) for which claims are submitted after the period for which the eligible applicant will receive payments.

(c) A managed long term care plan shall have its premiums determined in accordance with the insurance law except where enrollees are eligible to receive services under title XIX of the federal social security act, in which case rates shall be established pursuant to subdivision eight of this section.

5. Applicability of other laws.

(a) A managed long term care plan or approved managed long term care demonstration shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the

provisions of this section shall prevail.

(b) Notwithstanding chapter thirty-nine of the laws of nineteen hundred ninety-seven, the provisions of this section shall apply to the chronic care management demonstration authorized by such chapter.

6. Approval authority.

(a) The commissioner, pursuant to a request for proposals selection process, after receiving from the superintendent of insurance the evaluations and approvals required pursuant to this section, shall issue no more than twenty-four certificates of authority to eligible applicants for a managed long term care plan which satisfies the conditions under this section, provided that:

(i) for the purposes of issuance of no more than twenty-four certificates, such certificates shall be exclusive of those certificates issued pursuant to paragraphs (b) and (c) of this subdivision, provided, however, that such certificates shall be inclusive of those certificates issued to entities initially authorized to operate as an approved managed long term care demonstration pursuant to paragraph (e) of this subdivision;

(ii) no more than five of the twenty-four certificates of authority, inclusive of those certificates issued to entities initially authorized to operate as an approved managed long term care demonstration pursuant to paragraph (e) of this subdivision may be issued to eligible applicants which are, or are owned or controlled by one or more entities that have received a certificate of authority pursuant to either section forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of this article (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization organized under article forty-three of the insurance law provided further, that no more than one such certificate may be issued to an eligible applicant described in this subparagraph in the first twelve months following the effective date of this section, and no more than two such certificates may be issued to eligible applicants described in this subparagraph in the first twelve months commencing with the selection, pursuant to a request for proposals, of eligible applicants to operate managed long term care plans pursuant to this paragraph. For purposes of this subparagraph, "control" shall exist if an entity or entities designated in this subparagraph directly or indirectly own, control, or hold the power to vote ten percent or more, in the aggregate, of the voting securities or voting rights of such eligible applicant, or are corporate members of an eligible applicant organized as a not-for-profit corporation;

(iii) absent federal approvals as may be necessary to achieve the full capitation requirements of paragraph (g) of subdivision three of this section, the commissioner shall approve no more than eight certificates of authority pursuant to this paragraph to

operate a managed long term care plan which requires such federal approvals.

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance as stated in this section, that such demonstration complies with the operating requirements for a managed long term care plan under this section. Except as otherwise expressly provided in paragraphs (d) and (e) of subdivision seven of this section, nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) An approved managed long term care demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance set forth in this section, that such demonstration complies with the operating requirements for a managed long term care plan under this section. Notwithstanding any inconsistent provision of law to the contrary, all authority for the operation of approved managed long term care demonstrations which have not been issued a certificate of authority as a managed long term care plan, shall expire one year after the adoption of regulations implementing managed long term care plans.

(d) The commissioner may, contingent upon approval of federal waivers and subject to the approval of the director of the budget, authorize the continuing care network demonstration program sites in Monroe county to operate as approved managed long term care demonstrations and may permit such sites to serve enrollees who are sixty-five and older and not chronically ill.

(e) The majority leader of the senate and the speaker of the assembly may each designate in writing up to four eligible applicants as approved managed long term care demonstrations. Subsequent to such designation, the commissioner and the superintendent of insurance shall impose terms and conditions pursuant to a written agreement with each such demonstration, not inconsistent with this section, under which such demonstrations shall be authorized to operate.

(f) The commissioner and the superintendent of insurance shall impose terms and conditions pursuant to a written agreement with each approved managed long term care demonstration, not inconsistent with this section, under which such demonstrations shall be authorized to operate.

7. Program oversight and administration.

(a)(i) The commissioner shall promulgate regulations to implement this section and to ensure the quality, appropriateness and cost-effectiveness of the services provided by

managed long term care plans. The commissioner may waive rules and regulations of the department, including but not limited to, those pertaining to duplicative requirements concerning record keeping, boards of directors, staffing and reporting, when such waiver will promote the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of enrollees will not be impaired as a result of such waiver. In order to achieve managed long term care plan system efficiencies and coordination and to promote the objectives of high quality, integrated and cost effective care, the commissioner may establish a single coordinated surveillance process, allow for a comprehensive quality improvement and review process to meet component quality requirements, and require a uniform cost report. The commissioner shall require managed long term care plans to utilize quality improvement measures, based on health outcomes data, for internal quality assessment processes and may utilize such measures as part of the single coordinated surveillance process.

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation.

(b) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. Copies of such original waiver applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

(c)(i) The commissioner may establish interim enrollment thresholds which are less than the projected total enrollment in a plan for the purpose of making a determination of the plan's ability to enroll additional persons above the established thresholds while providing high quality and accessible care. Total enrollment of persons enrolled in managed long term care plans certified under paragraph (a) of subdivision six of this section or initially authorized to operate as an approved managed long term care demonstration under paragraph (e) of such subdivision, shall not exceed, in the aggregate, twenty-five thou- sand persons who were chronically ill and eligible for services

under title XIX of the federal social security act at the time of enrollment and twenty-five thousand persons who were not chronically ill at the time of enrollment.

(ii) A managed long term care plan shall not use deceptive or coercive marketing methods to encourage participants to enroll. A managed long term care plan shall not distribute marketing materials to potential enrollees until such plan has submitted such materials to the commissioner, the superintendent of insurance and the director of the state office for the aging.

(iii) The commissioner shall ensure, through periodic reviews of managed long term care plans, that enrollment was a voluntary and informed choice; such plan has only enrolled persons whom it is authorized to enroll, and plan services are promptly available to enrollees when appropriate. Such periodic reviews shall be made according to standards as determined by the commissioner in regulations.

(d) Notwithstanding any provision of law, rule or regulation to the contrary and subject to the availability of funds, the commissioner shall issue a request for proposals to carry out reviews of enrollment and assessment activities in managed long term care plans and operating demonstrations with respect to enrollees eligible to receive services under title XIX of the federal social security act to determine if enrollment meets the requirements of subparagraph (iii) of paragraph (c) of this subdivision; and that assessments of such enrollees' health, functional and other status, for the purpose of adjusting premiums, were accurate. The request for proposals shall be developed, and proposals evaluated, in consultation with the local commissioners representing the several regions of the state. Evaluations shall address each bidder's ability to ensure that enrollments in such plans are promptly reviewed and that medical assistance required to be furnished pursuant to title eleven of article five of the social services law will be appropriately furnished to the recipients for whom the local commissioners are responsible pursuant to section three hundred sixty-five of such title and that plan implementation will be consistent with the proper and efficient administration of the medical assistance program and managed long term care plans.

(e) Until such time as the provisions of paragraph (d) of this subdivision and the risk adjustment mechanisms referred to in subdivision eight of this section are both implemented to the satisfaction of the commissioner or January first, nineteen hundred ninety-nine, whichever is earlier:

(i) with respect to each managed long term care plan, the commissioner may continue to delegate some, or all, of the tasks identified in paragraph (d) of this subdivision to local districts provided that the agreement between the department and such plan pursuant to paragraph (o) of subdivision two of section three hundred sixty-five-a of the social services law or between the department and such demonstration clearly reflects such delegation;

(ii) an operating demonstration shall, with respect to tasks performed by the local district in relation to such demonstrations, have the option of continuing to operate under its existing agreement with a local district or, in the event that an approved managed long term care demonstration enters into a subsequent agreement with such district, to operate under the same or similar terms and conditions as contained in such subsequent agreement with respect to such tasks.

(f) The commissioner shall set a schedule for achievement of full capitation for services reimbursed under title XIX of the federal social security act which shall reflect the shortest feasible timelines consistent with any federal approvals required to achieve full capitation and the commissioner shall monitor each managed long term care plan's movement to full capitation according to such schedule.

(g) The commissioner shall ensure that protocols for benefit coordination, if applicable, have been implemented and are consistent with the requirements of this section.

(h) The commissioner may, in his or her discretion for the purpose of protection of enrollees, impose measures including, but not limited to, bans on further enrollments and requirements for use of enrollment brokers until any identified problems are resolved to the satisfaction of the commissioner.

(i) Continuation of a certificate of authority issued under this section, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance, shall be contingent upon satisfactory performance by the managed long term care plan in the delivery, continuity, accessibility, cost effectiveness and quality of the services to enrolled members; compliance with applicable provisions of this section and rules and regulations promulgated thereunder; the continuing fiscal solvency of the organization; and, federal financial participation in payments on behalf on enrollees who are eligible to receive services under title XIX of the federal social security act.

(j) The commissioner shall ensure that

(i) process exists for the resolution of disputes concerning the accuracy of assessments performed pursuant to paragraphs (d) and (e) of this subdivision; and

(ii) the tasks described in paragraphs (d) and (e) of this subdivision are consistently administered.

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner, in consultation with the superintendent of insurance,

shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates may be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner in consultation with the superintendent of insurance. Any such risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories.

9. Reports. The department shall provide an interim report to the governor, temporary president of the senate and the speaker of the assembly on or before April first, two thousand three and a final report on or before April first, two thousand six on the results of the managed long term care plans under this section. Such results shall be based on data provided by the managed long term care plans and shall include but not be limited to the quality, accessibility and appropriateness of services; consumer satisfaction; the mean and distribution of impairment measures of the enrollees by payor for each plan; the current method of calculating premiums and the cost of comparable health and long term care services provided on a fee-for-service basis for enrollees eligible for services under title XIX of the federal social security act; and the results of periodic reviews of enrollment levels and practices. Such reports shall contain a section prepared by the superintendent of insurance as to the results of the plans approved in accordance with this section concerning the matters regulated by the superintendent of insurance. Such reports shall also provide data on the demographic and clinical characteristics of enrollees, voluntary and involuntary disenrollments from plans, utilization of services and shall examine the feasibility of increasing the number of plans that may be approved. Data collected pursuant to this section shall be available to the public in an aggregated format to protect individual confidentiality, however under no circumstance will data be released on items with cells with smaller than statistically acceptable standards.

10. Managed long term care advisory council.

(a) There is hereby established a council to advise the commissioner and the superintendent of insurance on issues related to managed long term care. The council shall consist of thirteen members who shall be appointed as follows: seven by the governor, one of whom shall serve as the chair; two each by the temporary president of the senate and the speaker of the assembly; and one each by the minority leader of the senate and the minority leader of the assembly. The appointees shall be persons knowledgeable in the delivery or financing of continuing care services, or shall have a

demonstrated commitment to improving the quality of care to the elderly, the chronically ill and the disabled, or shall be persons who are enrolled in a managed long term care plan or demonstration operating under this section, or their representatives. No fewer than five of the thirteen members shall be persons who are enrolled in a plan or demonstration operating under this section, or their representatives. In addition to the thirteen appointed members, the commissioner, the superintendent of insurance and the director of the office for the aging shall serve as non-voting ex-officio members of the advisory council.

(b) The council shall:

(i) review data and reports provided by the plans related to demo- graphic and clinical characteristics of enrollees, consumer satisfaction and complaints, the number and reasons for voluntary and involuntary disenrollments, service utilization and costs as compared to fee-for- service;

(ii) review the managed long term care plans' progress on meeting enrollment targets and their marketing practices;

(iii) evaluate the adequacy of plans' efforts to integrate health and long term care services and benefit coordination;

(iv) advise the commissioner and the superintendent of insurance on strategies to increase the private and public/private financing of such plans;

(v) advise the commissioner and the superintendent of insurance on the feasibility of increasing the caps on enrollment or the number of plans that may be approved; and

(vi) review and comment on the reports prepared pursuant to subdivision nine of this section.

* NB Repealed December 31, 2006

§ 4404. Health maintenance organizations; continuance of certificate of authority.

1. Continuance by the commissioner of a certificate of authority issued under section forty-four hundred three of this article shall be contingent upon satisfactory performance by the organization as to the delivery, continuity, accessibility and quality of the services to which an enrolled member is entitled, compliance with the provisions of this article and rules and regulations promulgated thereunder, and the continuing fiscal solvency of the organization as set out in this section.

2. Except as provided in subdivision three of this section, the commissioner may

revoke, limit or annul a certificate of authority as of the termination of the current period of all then existing enrollee contracts, after a hearing, and only after a finding of unsatisfactory performance or fiscal insolvency. However, in the event of such revocation, limitation or annulment, the organization shall be prohibited from entering into any new enrollee contracts as of the date of notification of such action by the commissioner. Notification of such action shall be given by the organization to each enrollee. The commissioner shall give prior notice of such action to the superintendent.

3. The commissioner may revoke or limit a certificate of authority, after a hearing, for violations of any applicable statute or rules and regulations which threatened to directly affect the health, safety or welfare of any enrollee. Upon notice of his intent to revoke or limit a certificate of authority, the commissioner may prohibit the organization from entering into any new enrollee contracts pending final action and may require notification of such action to be given by the organization to each enrollee. The commissioner shall give prior notice to the superintendent of his intent to prohibit the organization from entering into any enrollee contracts. In any action pursuant to this subdivision, the commissioner and the superintendent shall take action to assure the continued insurance coverage of enrollees of the organization.

4. In addition to, or in lieu of, any revocation, limitation or annulment, the commissioner may assess a penalty pursuant to section twelve of this chapter for any violation of this chapter or rules and regulations promulgated pursuant to this article.

5. All orders or determinations made in accordance with the provisions of this section shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered mail of a copy of the order or determination upon the organization.

§ 4405. Health maintenance organizations; powers. The powers of health maintenance organizations, in addition to any other powers conferred by the laws under which such organization is constructed, shall include:

1. subject to the provisions of article twenty-eight of this chapter, the purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

2. the furnishing of comprehensive health care services on a prepaid basis through hospitals and other health care providers which are under contract with, otherwise associated with, or employed by the health maintenance organization;

3. the marketing, enrollment and administration of a comprehensive health services plan;

4. the contracting with an insurer licensed in this state;

5. the offering, in addition to health care services, of benefits covering out-of-area or emergency services;

6. the provision of additional health services not included in the comprehensive health services plan on a fee-for-service basis, the provision of health services on a fee-for-service basis to persons who are not members of the enrolled population;

7. the entering into contracts in furtherance of the purposes of this article;

8. the acceptance from government agencies, private agencies, corporations, associations, groups, individuals, or other persons, payments covering all or part of the cost of health care services provided to enrollees, in accordance with the provisions of the plan and this chapter; and

9. the indemnification of enrollees for the services of health care providers, other than primary care practitioners responsible for supervising and coordinating the care of enrollees, not participating in a plan to the extent authorized in section forty-four hundred six of this article; and

10. notwithstanding any other provision of law, to advertise the comprehensive health services which it renders and the plan relating to the rendition of such services, provided, however, that all information disseminated to the public shall be strictly factual in nature and accurate in all respects and shall not in any way be misleading to the public.

§ 4405-a. Immunizations against poliomyelitis, mumps, measles, diphtheria and rubella.

1. It shall be the duty of the administrative officer or other person in charge of each health maintenance organization, as defined in this article, to inquire of each person in its care under the age of eighteen, or of a person in parental relation to such person, whether all necessary immunizations have been received for poliomyelitis, mumps,

measles, diphtheria and rubella and, if not, to make available such immunizations and a certificate or certificates of such immunizations.

2. This section shall not apply to children whose parent, parents, or guardian are bona fide members of a recognized religious organization whose teachings are contrary to the practices herein required.

3. If any physician licensed to practice medicine in this state certifies that any such immunization may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization is found no longer to be detrimental to the child's health.

§ 4405-b. Duty to report.

1. (a) A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this chapter shall make a report to the appropriate professional disciplinary agency within thirty days of the occurrence of any of the following:

(i) the termination of a health care provider contract pursuant to section forty-four hundred six-d of this article for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare;

(ii) the voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures; or

(iii) the termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.

(b) An organization shall make a report to be made to the appropriate professional disciplinary agency within sixty days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in article one hundred thirty or one hundred thirty-one-A of the education law. A violation of this subdivision shall not be subject to the provisions of section twelve-b of this chapter.

2. Reports of possible professional misconduct made pursuant to this section shall be made in writing to the appropriate professional disciplinary agency. Written reports shall include the following information:

(a) the name, address, profession and license number of the individual; and

(b) a description of the action taken by the organization including the reason for the action and the date thereof, or the nature of the action or conduct that led to the resignation, termination of contract or withdrawal, and the date thereof stated with sufficient specificity to allow a reasonable person to understand which of the reasons enumerated led to the action of the organization or the resignation or withdrawal of the individual, and, if the reason was an act or omission of the individual, the particular act or omission.

3. (a) Any report or information furnished to an appropriate professional discipline agency in accordance with the provisions of this section shall be deemed a confidential communication and shall not be subject to inspection or disclosure in any manner except upon formal written request by a duly authorized public agency or pursuant to a judicial subpoena issued in a pending action or proceeding.

(b) Any person, facility, organization or corporation which makes a report pursuant to this section in good faith without malice shall have immunity from any liability, civil or criminal, for having made such report. For purposes of any proceeding, civil or criminal, the good faith of any person required to make a report shall be presumed.

§ 4406. Health maintenance organizations; regulation of contracts.

1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate under- standing and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of fifty or fewer employees or members, exclusive of spouses and dependents, or any employee or member of the group, including dependents, applying for such contract at any time throughout the year, and may include a pre-existing condition provision as provided for in section four thousand three hundred eighteen of the insurance law. Subject to the creditable coverage requirements of subsection (a) of section four thousand three hundred eighteen of the insurance law, the organization may, as an alternative to the use of a pre-existing condition provision, elect to offer contracts without a pre-existing condition provision to such groups but may require that coverage shall not become effective until after a specified affiliation period of not more than sixty days after the application for coverage is submitted. The organization is not required to provide health care services or benefits during such period and no premium shall be charged for any coverage during that period. After January first, nineteen hundred ninety-six, all individual direct payment contracts shall be issued only pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-

two of the insurance law. Such contracts may not, with respect to an eligible individual (as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. § 300gg-41(b), imposed any pre-existing condition exclusion.

2. (a) Upon approval of the commissioner, an organization may implement an out-of-plan benefits system that allows enrollees to use providers not participating in the plan pursuant to a contract, employment or other association. The commissioner, in consultation with the superintendent, shall not approve an organization to implement an out-of-plan benefits system unless the organization demonstrates that:

(i) the requirements of this article and any regulations promulgated thereunder have been met and will continue to be met;

(ii) it can establish and maintain a contingent reserve fund of not less than two percent of the entire net premium income for the calendar year of the organization in addition to any other contingent reserve fund required by the commissioner in regulations subject to the approval of the superintendent; and

(iii) it has established mechanisms to ensure and monitor compliance with the provisions of paragraph (b) of this subdivision.

(b) Except as provided in paragraph (c) of this subdivision, an organization may not permit the benefits provided pursuant to such out-of- plan system to exceed ten percent of the total health care expenditures of the organization, as determined on a quarterly basis, but such limitation shall not apply to individual direct payment contracts issued pursuant to section forty-three hundred twenty-two of the insurance law. In determining the amount of benefits provided in connection with the use of such providers, an organization shall not include benefits provided pursuant to a referral made by a participating provider or benefits provided in emergency situations.

(c) An organization may exceed the ten percent level by up to two percent in any given quarter provided that the organization does not exceed the ten percent level by the end of the following quarter.

(d) If the commissioner determines that an organization has permitted the benefits permitted by paragraph (b) or (c) of this subdivision, the commissioner may, where appropriate, assess an organization a civil penalty not to exceed the amount determined by multiplying the percentage permitted in excess of ten percent by the amount, in dollars, of the difference between what the organization paid all inpatient hospitals for such year and the amount such organization would have paid such hospitals had it been a payor within the categories specified in paragraph (b) of subdivision one of section twenty-eight hundred seven-c of this chapter and not authorized to negotiate hospital rates. The commissioner, in consultation with the

superintendent, may revoke, suspend or limit an approval issued pursuant to this subdivision for non-compliance by the organization with any of the provisions of this article or the rules and regulations promulgated thereunder.

(e) The indemnification of enrollees of the services of a non-participating provider may be subject to deductibles, copayments and/or coinsurance approved by the superintendent.

(f) Nothing in this subdivision shall be construed to limit an organization's ability to manage the care of enrollees or the types of health services covered, to conduct utilization review of quality assurance activities.

(g) The commissioner may prohibit an organization determined to have an inadequate network of participating providers from permitting new elections pursuant to this subdivision as of the date of notification of such determination by the commissioner. Notification of such action shall be given by the organization to each enrollee.

(h) An organization providing comprehensive health services under one or more assumed names shall be deemed to be offering its plan through a line of business corresponding to each such assumed name. An organization may, pursuant to the provisions of this subdivision, permit enrollees of one or more lines of business to elect to receive services from providers not participating in such line or lines of business provided, however, that with respect to each line of business such elections shall be permitted only to the extent authorized pursuant to paragraphs (b) and (c) of this subdivision.

(i) Nothing herein shall be deemed to prohibit a health maintenance organization from offering services in connection with a company appropriately licensed pursuant to the insurance law.

3. Nothing in this section shall be construed to require a health maintenance organization in its provision of a comprehensive health services plan to meet the requirements of an insurer under the insurance law.

4. If an enrollee requires nursing facility placement and is a resident of a continuing care retirement community authorized under article forty-six of this chapter, the enrollee's primary care practitioner must refer the enrollee to that community's nursing facility if medically appropriate; if the facility agrees to be reimbursed at the health maintenance organization's contract rate negotiated with similar providers for similar services and supplies, or negotiates a mutually agreed upon rate; and if the facility meets the health maintenance organization's guidelines and standards for the delivery of medical services.

§ 4406-a. Arbitration provisions of health maintenance organization contracts.

1. The enrollee contract of a health maintenance organization may permit enrollees and adult members of the enrollee's family who are covered by such contract to elect to have all claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered pursuant to the contract by a physician, dentist, hospital, health maintenance organization or other health care provider subject to binding arbitration, pursuant to article seventy-five-A of the civil practice law and rules. For the purposes of this section, "health maintenance organizations" shall include those health maintenance organizations organized pursuant to this article or pursuant to article forty-three of the insurance law. The enrollee contract may permit arbitration elections to be executed on behalf of minor children or persons judicially determined to be incompetent by a parent, legal guardian, committee or conservator or other person legally authorized to enroll the minor or incompetent person in a health maintenance organization. Arbitration election notices, described in subdivisions two and three of this section, must be executed by covered adult family members in order to bind such persons to the arbitration election.

2. After receiving the approval of the superintendent of insurance, pursuant to section five thousand six hundred five of the insurance law, health maintenance organizations may provide arbitration election notices to current enrollees and their covered adult family members. Such notice shall contain the following provision in at least twelve point boldface type immediately above spaces for the signature of the enrollee or covered adult family member: "By signing this form, I am agreeing to have any issue of alleged health care malpractice decided by neutral arbitration rather than by a court trial before a judge or jury. (Health care malpractice means claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered pursuant to my health maintenance organization contract by the health maintenance organization, a physician, dentist, hospital or other health care provider.) I understand that I will be given the opportunity to cancel my agreement, but that all claims arising during the time of my agreement will be subject to arbitration. I understand that by signing the form, I am deemed to have received and reviewed the information describing arbitration that has been provided to me. I also understand that there is no requirement that I sign this form and that my decision not to sign this form will not in any way affect my membership or benefits in this health maintenance organization."

3. After receiving the approval of the superintendent of insurance, pursuant to section five thousand six hundred five of the insurance law, health maintenance organizations may also provide arbitration election notices, as specified in subdivision two of this section, to new enrollees and their covered adult family members. In the alternative, a health maintenance organization may, after receiving the superintendent's approval, elect to provide an alternative notice to new enrollees and their

covered adult family members that provides that new enrollees and their covered adult family members shall be subject to the arbitration of claims unless a form is executed by such persons that declines consent to the arbitration of claims. A health maintenance organization that chooses to provide such alternative notice shall provide an arbitration declination form and notice to all new enrollees and their covered adult family members with the following provision in a least twelve point boldface type immediately above spaces for the signature of the enrollee or covered adult family member: "Unless you sign this form to decline the option of arbitration, by electing to enroll in this health maintenance organization, you are agreeing to have any issue of health care malpractice decided by neutral arbitration rather than by a court trial before a judge or jury. (Health care malpractice means all claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered pursuant to your health maintenance organization contract by the health maintenance organization, a physician, dentist, hospital or other health care provider.) If you do not sign this form to decline arbitration you will be given the opportunity to cancel your agreement to arbitrate these claims, but all claims arising prior to the time that you cancel the agreement will be subject to arbitration. You are entitled to receive information describing arbitration before making this decision. Your decision to sign this form to decline arbitration will not in any way affect your membership or benefits in this health maintenance organization."

4. Arbitration election notices may be provided, from time to time, by health maintenance organizations to persons who have not agreed to arbitration of such claims. The health maintenance organizations shall, in a form and manner determined to be sufficient by the superintendent of insurance and on at least an annual basis, provide notice to persons who have agreed to arbitration of such claims that such persons may cancel their agreement to arbitrate, including information as to how such person may cancel the arbitration agreement; provided, however, that the agreement to arbitrate shall remain in force during such person's enrollment or membership in the health maintenance organization unless the health maintenance organization receives notification of such person's cancellation of the arbitration agreement or the health maintenance organization withdraws its agreement to arbitrate and provides notice of this fact to persons who elected arbitration.

5. Every such notice shall be accompanied by or be part of an information brochure, prepared in accordance with section five thousand six hundred four of the insurance law, which clearly explains the nature and scope of arbitration and the procedures that will be used to conduct these arbitration proceedings.

6. All claims arising from surgical, medical, dental and other health care procedures performed or failed to be performed and treatment provided or failed to be provided by a physician, dentist, hospital, health maintenance organization or other health care provider pursuant to the enrollee contract to an enrollee or a covered adult family

member who signs the arbitration election notice or who fails to sign the arbitration declination form specified in subdivision three of this section shall be subject to arbitration and such enrollees or covered adult family members shall be bound by the agreement to arbitrate such claims. All physicians, dentists, hospitals, health maintenance organizations and other health care providers who provide or receive compensation for health care services pursuant to the enrollee contract shall be bound by the agreement to arbitrate.

7. Notwithstanding any inconsistent provisions of law, an agreement to arbitrate which complies with the provisions of this section shall be presumed valid.

§ 4406-b. Primary and preventive obstetric and gynecologic care.

1.The health maintenance organization shall not limit a female enrollee's direct access to primary and preventive obstetric and gynecologic services from a qualified provider of such services of her choice from within the plan to less than two examinations annually for such services or to any care related to a pregnancy. In addition, the health maintenance organization shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition, provided that such qualified provider discusses such services and treatment plan with the enrollee's primary care practitioner in accordance with the requirements of the health maintenance organization.

2. It shall be the duty of the administrative officer or other person in charge of each health maintenance organization to advise each female enrollee, in writing, of the provisions of this section.

§ 4406-c. Prohibitions.

1. For purposes of this section, "health care plan" shall mean a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article or an independent practice association certified or recognized pursuant to this article or a medical group.

2. No health care plan shall by contract or written policy or written procedure prohibit or restrict any health care provider from disclosing to any subscriber, enrollee, patient, designated representative or, where appropriate, prospective enrollee, (hereinafter collectively referred to as enrollee) any information that such provider deems appropriate regarding:

(a) a condition or a course of treatment with an enrollee including the availability of other therapies, consultations, or tests; or

(b) the provisions, terms, or requirements of the health care plan's products as they relate to the enrollee, where applicable.

3. No health care plan shall by contract, written policy or written procedure prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such health care plan which the provider believes may negatively impact upon the quality of, or access to, patient care.

4. No health care plan shall by contract, written policy or written procedure prohibit or restrict any health care provider from advocating to the health care plan on behalf of the enrollee for approval or coverage of a particular course of treatment or for the provision of health care services.

5. No contract or agreement between a health care plan and a health care provider shall contain any clause purporting to transfer to the health care provider, other than a medical group, by indemnification or otherwise any liability relating to activities, actions or omissions of the health care plan as opposed to those of the health care provider.

5-a. Contracts entered into between a plan and a health care provider shall include terms which prescribe:

(a) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(b) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

(c) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(d) the process to be employed to resolved disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; and

(e) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contract through a proceeding under article seventy-five of the civil practice law and rules.

5-b. No contract entered into with health care providers shall be enforceable if it includes terms which transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of section forty-four hundred three of this article, or penalize providers for unfavorable case mix so as to jeopardize the quality of or enrollees' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed primafacie to jeopardize quality or access.

6. Any contract provision, written policy or written procedure in violation of this section shall be deemed to be void and unenforceable.

§ 4406-d. Health care professional applications and terminations.

1. A health care plan shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the health care plan. The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements.

2. (a) A health care plan shall not terminate a contract with a health care professional unless the health care plan provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

(b) The notice of the proposed contract termination provided by the health care plan to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by the health care plan;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing; and

(iv) a time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

(c) The hearing panel shall be comprised of three persons appointed by the health care plan. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.

(d) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the health care plan, provisional reinstatement subject to conditions set forth by the health care plan or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(e) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision; provided, however, that the provisions of paragraph (e) of subdivision six of section four thousand four hundred three of this article shall apply to such termination.

(f) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

3. Either party to a contract may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for purposes of this section.

4. A health care plan shall develop and implement policies and procedures to ensure that health care professionals are regularly informed of information maintained by the health care plan to evaluate the performance or practice of the health care professional. The health care plan shall consult with health care professionals in developing methodologies to collect and analyze health care professional profiling data. Health care plans shall provide any such information and profiling data and analysis to health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each

health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the health care professional's profile and to work cooperatively with the health care plan to improve performance.

5. No health care plan shall terminate a contract or employment, or refuse to renew a contract, solely because a health care provider has:

(a) advocated on behalf of an enrollee;

(b) filed a complaint against the health care plan;

(c) appealed a decision of the health care plan;

(d) provided information or filed a report pursuant to section forty-four hundred six-c of this article; or

(e) requested a hearing or review pursuant to this section.

6. Except as provided herein, no contract or agreement between a health care plan and a health care professional shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination and the opportunity for a hearing or review concerning such termination.

7. Any contract provision in violation of this section shall be deemed to be void and unenforceable.

8. For purposes of this section, "health care plan" shall mean a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article or an independent practice association certified or recognized pursuant to this article.

9. For purposes of this section, "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

§ 4406-e. Access to end of life care.

1. For the purposes of this section, "health care plan" means a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article.

2. Every health care plan that provides coverage for hospital, surgical or

medical care that includes coverage for acute care services shall provide an enrollee diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the patient's attending health care practitioner) with coverage for acute care services at an acute care facility licensed pursuant to article twenty-eight of this chapter specializing in the treatment of terminally ill patients, if the patient's attending health care practitioner, in consultation with the medical director of the facility, determines that the enrollee's care would appropriately be provided by the facility.

3. Notwithstanding the provisions of article forty-nine of this chapter, if the health care plan disagrees with the admission of or provision or continuation of care for the enrollee by the facility, the health care plan shall initiate an expedited external appeal in accordance with the provisions of paragraph (c) of subdivision two of section forty-nine hundred fourteen of this chapter, provided further, that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by the health care plan and the health care plan shall provide coverage and reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the enrollee's contract. The decision of the external appeal agent shall be binding on all parties. If the health care plan does not initiate an expedited external appeal, the health care plan shall reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the enrollee's contract.

4. A health care plan shall provide reimbursement for those services prescribed by this section at rates negotiated between the health care plan and the facility. In the absence of agreed upon rates, a health care plan shall pay for acute care at the facility's acute care rate under the Medicare program (Title XVIII of the federal Social Security Act), including the Part A rate for Part A services and the Part B rate for Part B services, and shall pay for alternate level care days at seventy-five percent of the acute care rate, including the Part A rate for Part A services and the Part B rate for Part B services.

5. Payment by a health care plan pursuant to this section shall be payment in full for the services provided to the enrollee. An acute care facility reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an enrollee for the services provided by the acute care facility pursuant to this section, except for the collection of copayments, coinsurance or visit fees, or deductibles for which the enrollee is responsible under the terms of the applicable contract.

6. No provision of this section shall be construed to require a health care plan to provide coverage for benefits not otherwise covered under the enrollee's contract.

§ 4407. Health maintenance organizations; employer requirements.

1. All employers subject to the provisions of the unemployment insurance law, except for those employers with fewer than twenty-five employees, shall include in any health benefits plan offered to their employees, the option of membership in a health maintenance organization which provides or offers a comprehensive health services plan in accordance with the provisions of this article, but only if such plan serves an area in which twenty-five of such employer's employees reside and the organization has been issued a certificate of authority by the commissioner.

2. For those employees of an employer represented by a bargaining representative, the offer of the health maintenance organization alternative shall be subject only to the collective bargaining process; for those employees not represented by a bargaining representative, the offer of the health maintenance organization alternative shall be made directly to the employee.

3. (a) If there is more than one health maintenance organization engaged in the provision of health services in the area in which the employees of the employer reside, and if:

(i) one or more of such organizations provides more than one-half of its comprehensive health services through physicians or other health professionals who are members of the staff of the organization or of a medical group (or groups) which contracts with the organization, and

(ii) one or more of such organizations provides its comprehensive health services through contracts with an individual practice association (or associations), individual physicians and other health professionals under contract directly with the organization, or a combination of an individual practice association (or associations), medical group (or groups), physicians who are members of the staff of the organization, and individual physicians and other health professionals under contract directly with the organization, then the employer shall, in accordance with regulations of the commissioner, be required to offer the option of enrollment in at least one organization described in subparagraph (i) of this paragraph and at least one organization described in subparagraph (ii) of this paragraph if the employer has twenty-five or more but fewer than two hundred employees. If the employer has two hundred or more employees and the employer's principal office in this state is located outside of the metropolitan region then the employer shall be required to offer the option of enrollment in at least two organizations described in subparagraph (i) of this paragraph and at least two organizations described in subparagraph (ii) of this paragraph. If the employer has two hundred or more employees and the employer's principal office in this state is located within the

metropolitan region then the employer shall be required to offer the option of enrollment in at least two organizations described in subparagraph (i) of this paragraph and at least two organizations described in subparagraph (ii) of this paragraph and an additional organization from either subparagraph. For the purposes of this section the metropolitan region is defined as the counties of Westchester, Rockland, New York, Kings, Queens, Richmond, Bronx, Nassau and Suffolk.

(b) If within any particular area of the state in which at least twenty-five of such employer's employees reside there are fewer health maintenance organizations described in subparagraph (i) or (ii) of paragraph (a) of this subdivision than the employer is required to offer, then additional health maintenance organizations from subparagraph (i) or (ii) of paragraph (a) of this subdivision shall be offered; provided, however, that no employer with fewer than two hundred employees shall be required to offer more than a total of two health maintenance organizations, and no employer with two hundred or more employees shall be required to offer more than a total of four health maintenance organizations (or five such organizations if the employer's principal office is located within the metropolitan region) in any particular area of the state. In the event fewer than the required total minimum number of health maintenance organizations are available in an area, the employer shall offer all health maintenance organizations then certified to issue subscriber contracts in that area. Nothing in this subdivision shall be deemed to prohibit an employer from choosing to offer more health maintenance organizations to its employees than are required under this subdivision.

4. No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between an employer and his employees.

§ 4408. Disclosure of information.

1. Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information which may be incorporated into the member handbook or the subscriber contract or certificate containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

(a) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(b) a description of all prior authorization or other requirements for treatments and

services;

(c) a description of utilization review policies and procedures used by the health maintenance organization, including:

(i) the circumstances under which utilization review will be undertaken;

(ii) the toll-free telephone number of the utilization review agent;

(iii) the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;

(iv) the right to reconsideration;

(v) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(vi) the right to designate a representative;

(vii) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;

(viii) a notice of the right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of insurance as required pursuant to subdivision five of section forty-nine hundred fourteen of this chapter, of the external appeal process established pursuant to title two of article forty-nine of this chapter and the timeframes for such appeals; and

(ix) further appeal rights, if any;

(d) a description prepared annually of the types of methodologies the health maintenance organization uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a health maintenance organization and a health care provider;

(e) an explanation of a subscriber's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a subscriber's financial responsibility, caps on payments for covered services and financial responsibility for non- covered health care procedures, treatments or services

provided within the health maintenance organization;

(f) an explanation of a subscriber's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization or by any provider without required authorization or when a procedure, treatment or service is not a covered health care benefit;

(g) a description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including: the right to file a grievance regarding any dispute between an enrollee and a health maintenance organization; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which enrollees may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

(h) a description of the procedure for providing care and coverage twenty-four hours a day for emergency services. Such description shall include a definition of emergency services; notice that emergency services are not subject to prior approval; and shall describe the enrollee's financial and other responsibilities regarding obtaining such services including when such services are received outside the health maintenance organization's service area;

(i) a description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(j) a description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(k) notice that an enrollee may obtain a referral to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral;

(l) notice that an enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(m) notice that an enrollee with

(i) a life-threatening condition or disease or

(ii) a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the enrollee's medical care and the procedure for requesting and obtaining such a specialist;

(n) notice that an enrollee with a

(i) a life-threatening condition or disease or

(ii) a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(o) a description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(p) a description of how the health maintenance organization addresses the needs of non-English speaking enrollees;

* (p-1) notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services from a qualified provider of such services of her choice from within the plan for no fewer than two examinations annually for such services or to any care related to pregnancy and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition;
* NB Effective January 1, 2003

(q) notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization; and

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee:

(a) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of

the health maintenance organization;

(b) provide a copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(c) provide a copy of the most recent individual, direct pay subscriber contracts;

(d) provide information relating to consumer complaints compiled pursuant to section two hundred ten of the insurance law;

(e) provide the procedures for protecting the confidentiality of medical records and other enrollee information;

(f) allow enrollees and prospective enrollees to inspect drug formularies used by such health maintenance organization; and provided further, that the health maintenance organization shall also disclose whether individual drugs are included or excluded from coverage to an enrollee or prospective enrollee who requests this information;

(g) provide a written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(h) provide a description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(i) provide individual health practitioner affiliations with participating hospitals, if any;

(j) upon written request, provide specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the organization might consider in its utilization review and the organization may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the organization, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization;

(k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization; and

(1) disclose other information as required by the commissioner, provided

that such requirements are promulgated pursuant to the state administrative procedure act.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

4. If a primary care provider ceases participation in the health maintenance organization, the organization shall provide written notice within fifteen days from the date that the organization becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and the health maintenance organization is aware of such ongoing course of treatment, the health maintenance organization shall provide written notice within fifteen days from the date that the health maintenance organization becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care pursuant to paragraphs (e) and (f) of subdivision six of section four thousand four hundred three of this article and for choosing an alternative provider.

5. Every health maintenance organization shall annually on or before April first, file a report with the commissioner and superintendent of insurance showing its financial condition as of the last day of the preceding calendar year, in such form and providing such information as the commissioner shall prescribe.

6. Every health maintenance organization offering to indemnify enrollees pursuant to subdivision nine of section forty-four hundred five and subdivision two of section forty-four hundred six of this article shall on a quarterly basis file a report with the commissioner and the superintendent of insurance showing the percentage utilization for the preceding quarter of non-participating provider services in such form and providing such other information as the commissioner shall prescribe.

***§ 4408-a. Integrated delivery systems.**

1. Legislative purpose and findings. The legislature intends to facilitate the ability of integrated delivery systems to assume a larger role in delivering a full array of health care services, from primary and preventive care through acute inpatient hospital and post-hospital care to a defined population for a determined price. The legislature finds that the formation and operation of integrated delivery systems under this section will promote the purposes of federal and state anti-referral statutes which are to reduce over-utilization and expenditures and finds that such statutes should not be interpreted to interfere with the development of such integrated delivery systems or impose liability for arrangements between an integrated delivery system certified pursuant to this section and its participating providers and entities. The legislature further finds that the development of

integrated delivery systems will reduce costs and enhance quality. It intends that systems acting pursuant to a certificate of authority issued under this section shall not be subject to state or federal antitrust liability for doing so.

2. Definitions. For the purposes of this section:

(a) "Applicant" means a separate legal entity created for the purpose of establishing and operating an integrated delivery system. Such entity shall be composed of or controlled by one or more affiliated providers or one or more affiliated groups of providers.

(b) Provider" means an entity licensed or certified under article twenty-eight or thirty-six of this chapter; an entity licensed or certified under article sixteen, twenty-three or thirty-one of the mental hygiene law; or a health care practitioner, or combination of health care practitioners, licensed under title eight of the education law. Every provider shall be:

(i) a natural person;

(ii) a partnership all of whose members are natural persons and that is not a limited partnership; or

(iii) a corporation none of whose stock is owned by another corporation.

3. The commissioner, after receiving from the superintendent of insurance the evaluations and approvals required pursuant to subdivision seven of this section, may issue a certificate of authority to an applicant which satisfies the conditions under this section for issuance established by the commissioner and which seeks to deliver comprehensive health services, on a capitated basis, including inpatient services, to:

(a) persons who are receiving benefits under title XVIII of the federal social security act; or

(b) persons who are receiving benefits under title XIX of the federal social security act and commercial enrollees; or

(c) an enrollee population which includes persons receiving benefits under titles XVIII and XIX of the federal social security act and commercial enrollees.

4. An applicant must demonstrate to the commissioner that it will provide at least seventy-five percent of the total expenditures for covered health care items and services directly to its enrollees through the provider, affiliated providers or affiliated groups of providers comprising such applicant. The applicant shall make arrangements or

referrals for any covered health care items and services not provided directly to its enrollees by such applicant.

5. A provider shall be deemed affiliated with another provider or group of providers if, through contract, ownership or otherwise:

(a) one provider, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than fifty-one percent of the voting rights or governance rights of another;

(b) each provider is a participant in a lawful combination under which each provider shares, either directly or indirectly, substantial financial risk in connection with the activities and services of such combination; or

(c) a provider is a corporate member of a provider organized as a not-for-profit corporation duly designated pursuant to section six hundred one of the not-for-profit corporation law.

6. The commissioner shall be responsible for evaluating, approving and regulating all matters relating to delivery systems, quality of care and access to care to be provided through the integrated delivery system. In performing this responsibility, the commissioner shall assure:

(a) that the formation and operation of the integrated delivery system will enhance access to health services in the area to be served; and

(b) subject to subdivision four of this section, the comprehensive health services will be provided by the applicant through its proposed delivery system (including through providers other than those composing, affiliated with or controlling the applicant).

7. (a) The superintendent of insurance, in consultation with the commissioner in accordance with a protocol to be specified in a memorandum of understanding between the commissioner and the superintendent of insurance regarding fiscal solvency, shall be responsible for evaluating, approving and regulating all matters relating to premium rates, subscriber contracts and fiscal solvency, including reserves, surplus and provider contracts to the extent such contracts relate to fiscal solvency matters. The superintendent of insurance, in the administration of this subdivision, shall:

(i) be guided by the standards which govern the fiscal solvency of a health maintenance organization, provided, however, that the superintendent of insurance shall recognize and consider the specific delivery components, operational capacity and financial capability of the applicant for a certificate of authority; and

(ii) not apply financial solvency standards that exceed those required for a health maintenance organization.

(b) Standards established pursuant to this subdivision shall be adequate to protect the interests of the subscribers to integrated delivery systems. The superintendent of insurance must be satisfied that the applicant is fiscally sound, and has made adequate provisions to pay for services:

(i) that are furnished by providers that are not affiliated with the applicant;

(ii) to meet the specialized health care needs of certain enrollees needing care at specialty care centers; and

(iii) for which claims are submitted after the period for which the applicant will receive payments.

8. The integrated delivery system shall have its premiums determined on a community-rated basis in accordance with the insurance law except where the enrollees are eligible to receive services under title XIX of the federal social security act in which case the premium rates shall be established by the commissioner, in consultation with the superintendent of insurance, subject to the approval of the director of the division of the budget.

9. An integrated delivery system shall be subject to the provisions of the insurance law that are applicable to health maintenance organizations, this chapter and regulations applicable to health maintenance organization, and any regulations promulgated by the commissioner or superintendent of insurance to implement this section. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

10. No certificate of authority for an integrated delivery system shall be issued pursuant to this section on or after April first, two thousand two and integrated delivery systems issued certificates before such date shall accept no new enrollees thereafter.

*NB There are 2 § 4408-a's

***§ 4408-a . Grievance procedure.**

1. A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article, and any other organization certified pursuant to this article shall establish and maintain a grievance procedure. Pursuant to such procedure, enrollees shall be entitled to seek a review of determinations by the organization other than determinations subject to the provisions of article forty-nine of this chapter.

2. (a) An organization shall provide to all enrollees written notice of the grievance procedure in the member handbook and at any time that the organization denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract; provided, however, that nothing herein shall be deemed to require a health care provider to provide such notice. In the event that an organization denies a service as an adverse determination as defined in article forty-nine of this chapter, the organization shall inform the enrollee or the enrollee's designee of the appeal rights provided for in article forty-nine of this chapter.

(b) The notice to an enrollee describing the grievance process shall explain:

(i) the process for filing a grievance with the organization;

(ii) the timeframes within which a grievance determination must be made; and

(iii) the right of an enrollee to designate a representative to file a grievance on behalf of the enrollee.

(c) The organization shall assure that the grievance procedure is reasonably accessible to those who do not speak English.

3. (a) The organization may require an enrollee to file a grievance in writing, by letter or by a grievance form which shall be made available by the organization and which shall conform to applicable standards for readability.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, an enrollee may submit an oral grievance in connection with:

(i) a denial of, or failure to pay for, a referral; or

(ii) a determination as to whether a benefit is covered pursuant to the terms of the enrollee's contract. In connection with the submission of an oral grievance, an organization may require that the enrollee sign a written acknowledgment of the grievance prepared by the organization summarizing the nature of the grievance. Such acknowledgment shall be mailed promptly to the enrollee, who shall sign and return the acknowledgment, with any amendments, in order to initiate the grievance. The grievance acknowledgment shall prominently state that the enrollee must sign and return the acknowledgment to initiate the grievance. If an organization does not require such a signed acknowledgment, an oral grievance shall be initiated at the time of the telephone call.

(c) Upon receipt of a grievance, the organization shall provide notice specifying what information must be provided to the organization in order to render a decision on the grievance.

(d) (1) An organization shall designate personnel to accept the filing of an enrollee's grievance by toll-free telephone no less than forty hours per week during normal business hours and, shall have a telephone system available to take calls during other than normal business hours and shall respond to all such calls no less than the next business day after the call was recorded.

(2) Notwithstanding the provisions of subparagraph one of this paragraph, an organization may, in the alternative, designate personnel to accept the filing of an enrollee's grievance by toll-free telephone not less than forty hours per week during normal business hours and, in the case of grievances subject to subparagraph (i) of subdivision four of this section, on a twenty-four hour a day, seven day a week basis.

4. Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than: (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and (iii) forty-five days after the receipt of all necessary information in all other instances.

5. The organization shall designate one or more qualified personnel to review the grievance; provided further, that when the grievance pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals.

6. The notice of a determination of the grievance shall be made in writing to the enrollee or to the enrollee's designee. In the case of a determination made in conformance with subparagraph (i) of subdivision four of this section, notice shall be made by telephone directly to the enrollee with written notice to follow within three business days.

7. The notice of a determination shall include:

(i) the detailed reasons for the determination;

(ii) in cases where the determination has a clinical basis, the clinical rationale for the determination; and

(iii) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.

8. An enrollee or an enrollee's designee shall have not less than sixty business days after receipt of notice of the grievance determination to file a written appeal, which may be submitted by letter or by a form supplied by the organization.

9. Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

10. The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

11. The organization shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:

(i) two business days after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; and

(ii) thirty business days after the receipt of all necessary information in all other instances.

12. The notice of a determination on an appeal shall include:

(i) the detailed reasons for the determination; and

(ii) in cases where the determination has a clinical basis, the clinical rationale for the determination.

13. An organization shall not retaliate or take any discriminatory action against an enrollee because an enrollee has filed a grievance or appeal.

14. An organization shall maintain a file on each grievance and associated appeal,

if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the enrollee's acknowledgment of the grievance, if any; the determination made by the organization including the date of the determination and the titles and, in the case of a clinical determination, the credentials of the organization's personnel who reviewed the grievance. If an enrollee files an appeal of the grievance, the file shall include the date and a copy of the enrollee's appeal, the determination made by the organization including the date of the determination and the titles and, in the case of clinical determinations, the credentials, of the organization's personnel who reviewed the appeal.

15. The rights and remedies conferred in this article upon enrollees shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.
*NB There are 2 § 4408-a's

§ 4409. Health maintenance organizations; examinations.

1. In order to carry out the provisions of this article, the commissioner, pursuant to his authority under section two hundred six of this chapter, shall examine not less than once every three years, each health maintenance organization and all participating entities through which such health maintenance organization offers health services as to the quality of health care services offered, and the adequacy of its provider arrangements.

2. The superintendent shall examine not less than once every three years into the financial affairs of each health maintenance organization, and transmit his findings to the commissioner. In connection with any such examination, the superintendent shall have convenient access at all reasonable hours to all books, records, files and other documents relating to the affairs of such organization, which are relevant to the examination. The superintendent may exercise the powers set forth in sections three hundred four, three hundred five, three hundred six and three hundred ten of the insurance law in connection with such examinations, and may also require special reports from such health maintenance organizations as specified in section three hundred eight of the insurance law.

3. The superintendent and the commissioner are authorized to share and exchange information obtained by them in the exercise of their respective responsibilities under the insurance law and this chapter.

4. Nothing contained in this section shall be deemed to require the public disclosure of privileged patient information.

§ 4410. Health maintenance organizations; professional services.

1. The provision of comprehensive health services directly or indirectly, by a health maintenance organization through its comprehensive health services plan shall not be considered the practice of the profession of medicine by such organization or plan. However, each member, employee or agent of such organization or plan shall be fully and personally liable and accountable for any negligent or wrongful act or misconduct committed by him or any person under his direct supervision and control while rendering professional services on behalf of such organization or plan.

2. Unless the patient waives the right of confidentiality, a health maintenance organization or its comprehensive health services plan shall not be allowed to disclose any information which was acquired by such organization or plan in the course of the rendering to a patient of professional services by a person authorized to practice medicine, registered professional nursing, licensed practical nursing, or dentistry, and which was necessary to acquire to enable such person to act in that capacity, except as may be otherwise required by law. A non-participating provider shall provide an enrollee's organization with such patient information as is reasonably required by the organization to administer its plan. In making such disclosure a provider shall comply with the provisions of subdivision six of section eighteen of this chapter concerning the disclosure of patient information to third parties provided, however, that with respect to a protected individual as defined in subdivision six of section twenty-seven hundred eighty of this chapter, disclosure shall be made only pursuant to an enrollee's written authorization and shall otherwise be consistent with the requirements of such section and rules and regulations promulgated pursuant thereto.

3. Notwithstanding the provisions of this section, the provisions of section four hundred twenty-two of the social services law shall apply to any information or reports submitted by a health maintenance organization to the statewide central register of child abuse and maltreatment reports.

4. (a) The commissioner shall have access to patient-specific medical information, including encounter data, maintained by a health maintenance organization or other organization certified pursuant to this article for the purposes of quality assurance and oversight, subject to any other limitations of federal and state law regarding disclosure thereof to third parties and subject to the provisions of this subdivision. The provisions of sections thirty-one hundred one, and forty-five hundred four, forty-five hundred seven and forty-five hundred eight of the civil practice law and rules, subdivision three of this section and section 33.13 of the mental hygiene law, shall not bar disclosure by the health maintenance organization to the commissioner for such purposes.

(b) The commissioner may only obtain enrollee information subject to the establishment of protocols that will ensure that such patient-specific information is not disclosed to third parties other than to entities serving as agents of the state for the purposes of quality assurance and oversight. Such protocols shall be developed in

consultation with representatives of health maintenance organizations, health care provider organizations and consumer organizations and shall, where possible, include the development of a unique confidential identifier to be used in connection with patient-specific data. These protocols shall address issues relating to the collection, maintenance, and disclosure of such patient-specific information. Such protocols shall be promulgated as regulations, provided however, that protocols or regulations in use prior to the effective date of this subdivision shall remain in effect until the regulations developed hereunder are promulgated.

(c) In addition to any other sanction or penalty as provided by law, any employee of the department who willfully violates this regulation or any other rule or procedure pertaining to the disclosure of any material collected pursuant to this subdivision shall be deemed to have committed an act of misconduct and shall be disciplined in accordance with the provisions of the civil service law.

§ 4411. Construction.

The provisions of laws other than this article shall not be applicable to the certification of any health maintenance organization under this article except where so specified; provided, however, that no health maintenance organization shall include in its name the words "insurer", "casualty", "health and accident" or any words generally regarded as descriptive of the insurance function; provided further, that this provision shall not be construed as prohibiting the participation in a comprehensive health services plan of any corporation or other entity organized under any other law, to the extent that such corporations or entities are authorized to participate by law, including but not limited to the insurance law, business corporation law, education law, not-for-profit corporation law, or general municipal law; nor shall this section be considered to prevent the application of any other law to the entities comprising such plan.

§ 4412. Separability.

If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

§ 4413. Savings clause.

Nothing contained in this article or any act amendatory thereof shall affect or impair the validity of any act done or right accruing, accrued or acquired or any order, judgment, or status established prior to the enactment of this article or prior to the amendment of any act amendatory thereof. Medical corporations organized pursuant to

the provisions of former article forty-four of the public health law in effect prior to the effectiveness of the provisions of this article may continue to operate pursuant to the provisions of law in effect prior to the effectiveness hereof. Health maintenance organizations that applied for a license under article forty-three of the insurance law and receive approval under article twenty-eight of the public health law may continue under the provisions of the laws in existence on the effective date of this article.

§ 4414. Health care compliance programs.

The commissioner of health, after consultation with the superintendent of insurance, shall by regulation establish standards and criteria for compliance programs to be implemented by persons providing coverage or coverage and service pursuant to any public or governmentally-sponsored or supported plan for health care coverage or services. Such regulations shall include provisions for the design and implementation of programs or processes to prevent, detect and address instances of fraud and abuse. Such regulations shall take into account the nature of the entity's business and the size of its enrolled population. The commissioner of health and the superintendent of insurance shall accept programs and processes implemented pursuant to section four hundred nine of the insurance law as satisfying the obligations of this section and the regulations promulgated thereunder when such programs and processes incorporate the objectives contemplated by this section.